FOR BHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032011

Facility Name: Norridge Healthcare & Rehab Centre

Address: 7001 West Cullom Avenue (Number) Norridge (City) 60706 (Zip Code)

County: Cook

Telephone Number: (708) 457-0700 **Fax #** (708) 457-8852

HFS ID Number: 36-3485852

Date of Initial License for Current Owners: 1-Jan-1987

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ March 31, 2006 (Date)

(Type or Print Name) Christopher Vicere

(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	210	Skilled (SNF)	210	76,650	1
2		Skilled Pediatric (SNF/PED)			2
3	105	Intermediate (ICF)	105	38,325	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	315	TOTALS	315	114,975	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	56,039	9,819	15,729	81,587	8
9	SNF/PED					9
10	ICF	5,321	761		6,082	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,360	10,580	15,729	87,669	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.25%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1-Jan-1987

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1-Jan-1987 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 210 and days of care provided 14,895

Medicare Intermediary AminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	621,891	59,687	20,787	702,365		702,365		702,365			1
2	Food Purchase		545,340		545,340	(24,375)	520,965	(535)	520,430			2
3	Housekeeping	380,790	96,079		476,869		476,869		476,869			3
4	Laundry	187,662	63,169		250,831		250,831		250,831			4
5	Heat and Other Utilities			322,142	322,142		322,142		322,142			5
6	Maintenance	99,937	101,297	103,111	304,345		304,345		304,345			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,290,280	865,572	446,040	2,601,892	(24,375)	2,577,517	(535)	2,576,982			8
	B. Health Care and Programs											
9	Medical Director			38,250	38,250		38,250		38,250			9
10	Nursing and Medical Records	4,850,768	610,241	359,120	5,820,129		5,820,129		5,820,129			10
10a	Therapy			6,971	6,971		6,971		6,971			10a
11	Activities	157,776	27,349	670	185,795		185,795		185,795			11
12	Social Services	108,910		3,845	112,755		112,755		112,755			12
13	CNA Training		1,441		1,441		1,441		1,441			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	5,117,454	639,031	408,856	6,165,341		6,165,341		6,165,341			16
	C. General Administration											
17	Administrative	118,248		502,740	620,988		620,988	(265,172)	355,816			17
18	Directors Fees											18
19	Professional Services			67,623	67,623		67,623	30,564	98,187			19
20	Dues, Fees, Subscriptions & Promotions			89,249	89,249		89,249	(63,602)	25,647			20
21	Clerical & General Office Expenses	351,638	72,999	241,075	665,712		665,712	(40,368)	625,344			21
22	Employee Benefits & Payroll Taxes			1,252,098	1,252,098	24,375	1,276,473	92,706	1,369,179			22
23	Inservice Training & Education							2,039	2,039			23
24	Travel and Seminar			9,997	9,997		9,997	8,757	18,754			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			16,653	16,653		16,653		16,653			26
27	Other (specify):* **Payroll Taxes**							30,427	30,427			27
28	**TOTAL General Administration**	469,886	72,999	2,179,435	2,722,320	24,375	2,746,695	(204,649)	2,542,046			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,877,620	1,577,602	3,034,331	11,489,553		11,489,553	(205,184)	11,284,369			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Norridge Healthcare & Rehab Centre #0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			124,297	124,297		124,297	633,499	757,796			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,145	7,145		7,145	1,491,137	1,498,282			32
33	Real Estate Taxes			533,885	533,885		533,885		533,885			33
34	Rent-Facility & Grounds			2,485,324	2,485,324		2,485,324	(2,484,000)	1,324			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			3,150,651	3,150,651		3,150,651	(359,364)	2,791,287			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		322,494	1,081,785	1,404,279		1,404,279		1,404,279			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			172,463	172,463		172,463		172,463			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		322,494	1,254,248	1,576,742		1,576,742		1,576,742			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,877,620	1,900,096	7,439,230	16,216,946		16,216,946	(564,548)	15,652,398			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	51,970	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(535)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,371)	24		19
20	Contributions	(850)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(187,490)	21		24
25	Fund Raising, Advertising and Promotional	(108,272)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(2,359)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (254,907)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(309,641)	6 & 6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (309,641)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (564,548)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Norridge Healthcare & Rehab Centre

ID# 0032011

Report Period Beginning: 1/1/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(535)	0	0	0	0	0	0	0	0	0	0	(535)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(535)	0	0	0	0	0	0	0	0	0	0	(535)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(265,172)	0	0	0	0	0	0	0	0	0	(265,172)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	30,564	0	0	0	0	0	0	0	0	0	30,564	19
20	Fees, Subscriptions & Promotions	(111,481)	47,879	0	0	0	0	0	0	0	0	0	(63,602)	20
21	Clerical & General Office Expenses	(190,490)	147,122	3,000	0	0	0	0	0	0	0	0	(40,368)	21
22	Employee Benefits & Payroll Taxes	0	92,706	0	0	0	0	0	0	0	0	0	92,706	22
23	Inservice Training & Education	0	2,039	0	0	0	0	0	0	0	0	0	2,039	23
24	Travel and Seminar	(4,371)	13,128	0	0	0	0	0	0	0	0	0	8,757	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	30,427	0	0	0	0	0	0	0	0	0	30,427	27
28	**TOTAL General Administration**	(306,342)	98,693	3,000	0	0	0	0	0	0	0	0	(204,649)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(306,877)	98,693	3,000	0	0	0	0	0	0	0	0	(205,184)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Norridge Healthcare & Rehab Centre **#** 0032011 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	51,970	949	580,580	0	0	0	0	0	0	0	0	633,499	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	19,044	1,472,093	0	0	0	0	0	0	0	0	1,491,137	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(2,484,000)	0	0	0	0	0	0	0	0	(2,484,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	51,970	19,993	(431,327)	0	0	0	0	0	0	0	0	(359,364)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(254,907)	118,686	(428,327)	0	0	0	0	0	0	0	0	(564,548)	45

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Officers' Salaries	$	Lancaster, Ltd.	100.00%	$ 167,918	$ 167,918	1
2	V		27	Payroll Taxes-Officers & Staff		Lancaster, Ltd.	100.00%	30,427	30,427	2
3	V		17	Management Fee Income	502,740	Lancaster, Ltd.	100.00%		(502,740)	3
4	V		19	Professional Services		Lancaster, Ltd.	100.00%	30,564	30,564	4
5	V		21	Clerical Expenses		Lancaster, Ltd.	100.00%	147,122	147,122	5
6	V		22	Employee Benefits		Lancaster, Ltd.	100.00%	92,706	92,706	6
7	V		24	Seminars & Travel		Lancaster, Ltd.	100.00%	13,128	13,128	7
8	V		17	Administrative Consulting		Lancaster, Ltd.	100.00%	69,650	69,650	8
9	V		20	Marketing and Fees		Lancaster, Ltd.	100.00%	45,605	45,605	9
10	V		32	Interest	7,145	Lancaster, Ltd.	100.00%	26,189	19,044	10
11	V		30	Depreciation		Lancaster, Ltd.	100.00%	949	949	11
12	V		20	Dues, Fees and Subscriptions		Lancaster, Ltd.	100.00%	2,274	2,274	12
13	V		23	Education & Inservice		Lancaster, Ltd.	100.00%	2,039	2,039	13
14	Total				$ 509,885			$ 628,571	$ * 118,686	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		34	Rental	$ 2,484,000		100.00%	$	$ (2,484,000)	15
16	V		32	Interest	27,907			1,500,000	1,472,093	16
17	V		30	Depreciation				580,580	580,580	17
18	V		21	IL State Replacement Tax				3,000	3,000	18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 2,511,907			$ 2,083,580	$ * (428,327)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Laurence Zung	Executive Officer	Administrative	40.00	See Attached	24	50.00	Lancaster	$ 105,000	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	6.00	See Attached	9	18.75	Lancaster	31,459	17-7	2
3	Cheryl Morris	VP-Operations	Administrative	6.00	See Attached	9	18.75	Lancaster	31,459	17-7	3
4	Sandra Bernett	Administrator	Administrative	5.00	See Attached	40	100.00	Lancaster	0	17-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 167,918		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, IL 60630
Phone Number: (773) 604-4416
Fax Number: (773) 478-1192

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Laurence Zung	Hours Worked	48	7	$ 210,000	$ 210,000	24	$ 105,000	1
2	27	Laurence Zung-payroll tax	Hours Worked	48	7	9,553		24	4,777	2
3	17	Christopher Vicere	Hours Worked	48	7	167,782	167,782	9	31,459	3
4	27	Christopher Vicere-payroll tax	Hours Worked	48	7	8,941		9	1,676	4
5	17	Cheryl Morris	Hours Worked	48	7	167,782	167,782	9	31,459	5
6	27	Cheryl Morris-payroll tax	Hours Worked	48	7	8,941		9	1,676	6
7										7
8										8
9										9
10										10
11										11
12										12
13	19	Professional Services	Management Fees	2,140,820	7	130,152		502,740	30,564	13
14	21	Clerical Expenses	Management Fees	2,140,820	7	626,489	553,344	502,740	147,122	14
15	22	Employee benefits	Management Fees	2,140,820	7	394,769		502,740	92,706	15
16	24	Seminars & Travel	Management Fees	2,140,820	7	55,902		502,740	13,128	16
17	17	Administrative Consulting	Management Fees	2,140,820	7	296,590	296,590	502,740	69,650	17
18	20	Marketing and Fees	Management Fees	2,140,820	7	194,202	180,270	502,740	45,605	18
19	32	Interest	Management Fees	2,140,820	7	(7,314)		502,740	(1,718)	19
20	30	Depreciation	Management Fees	2,140,820	7	4,042		502,740	949	20
21	20	Dues, Fees and Subscriptions	Management Fees	2,140,820	7	9,684		502,740	2,274	21
22	27	Payroll Taxes	Management Fees	2,140,820	7	94,951		502,740	22,298	22
23	23	Education & Inservice	Management Fees	2,140,820	7	8,681		502,740	2,039	23
24		*Direct Interest*							27,907	24
25	TOTALS					$ 2,381,147	$ 1,575,768		$ 628,571	25

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	JP Morgan Chase benk		X	Working Capital							(1,718)	6
7	Harston Investments		X	Working Capital							1,500,000	7
8												8
9	TOTAL Facility Related						$	$			$ 1,498,282	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 1,498,282	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Norridge Healthcare & Rehab Centre **#** 0032011 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	474,150	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	496,535	2
3. Under or (over) accrual (line 2 minus line 1).	$	22,385	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	511,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	533,885	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	447,232	8
	2001	437,929	9
	2002	438,817	10
	2003	464,854	11
	2004	496,535	12

****Accrual is based on 2004 taxes adjusted for inflation****

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Norridge Healthcare & Rehab Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032011

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-18-318-005-0000	Long-Term Healthcare	$ 123,943.18	$ 123,943.18
2.	13-18-318-006-0000	Long-Term Healthcare	$ 123,943.18	$ 123,943.18
3.	13-18-318-007-0000	Long-Term Healthcare	$ 124,705.46	$ 124,705.46
4.	13-18-318-008-0000	Long-Term Healthcare	$ 123,943.18	$ 123,943.18
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 496,535.00	$ 496,535.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,972 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nsg.Care Facility		1986	$ 650,000	1
2	Sect 754 basis adj.			126,788	2
3	TOTALS			$ 776,788	3

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1986	1976	$ 9,204,000	$ 460,200	30	$ 460,200	$	$ 7,194,460	4
5					1,315,965	41,777	30	41,777		570,491	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	43,548	1,382	20	2,177	795	39,392	9
10	Various			1988	3,940	125	20	197	72	3,983	10
11	Various			1988	28,574	459	20	724	265	29,245	11
12	Various			1989	1,297	41	20	65	24	1,151	12
13	Various			1990	3,827	121	20	191	70	3,277	13
14	Various			1990	28,644	909	20	1,433	524	21,773	14
15	Various			1991	72,916	2,314	20	3,650	1,336	51,843	15
16	Various			1992	36,639	1,352	20	1,944	592	25,231	16
17	Various			1993	72,513	1,921	20	3,627	1,706	44,081	17
18	Various			1994	116,353	3,049	20	5,853	2,804	63,972	18
19	Various			1995	95,409	2,448	20	4,760	2,312	49,837	19
20	Boiler/Hot Water Heater Improvements			1996	9,417	241	20	471	230	4,479	20
21	Tuckpointing			1999	28,900	741	20	1,445	704	9,853	21
22	Architect Fee 1st Floor			2001	15,052	386	20	386		1,882	22
23	Construction 1st Floor			2001	166,662	4,273	20	4,273		20,832	23
24	Construction Library			2001	12,461	320	20	320		1,559	24
25	Design Fee-1st Floor			2001	5,130	132	20	132		643	25
26	Sprinklers-1st Floor			2001	4,531	116	20	116		566	26
27	Demolition-1st Floor			2001	5,533	142	20	142		692	27
28	Wooden Doors (2)			2001	1,134	29	20	29		142	28
29	Construction Work			2002	4,207	108	20	108		463	29
30	Smoking Shelter			2002	3,251	83	20	325	242	1,300	30
31	Auto Front Door			2002	2,074	53	20	207	154	742	31
32	Fence In Lot			2003	2,972	127	20	198	71	446	32
33	Building New-Town Square			2003	281,539	25,029	20	19,508	(5,521)	42,267	33
34	Roofing			2003	62,440	1,601	20	6,244	4,643	13,529	34
35	Wanderquard			2004	964	308	20	96	(212)	176	35
36	Refuse Inclosure			2004	2,395	766	20	240		320	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Fire alarm System	2004	$ 104,400	$ 33,408	20	$ 14,914	$ (18,494)	$ 26,100	37
38	Patio Concrete	2004	2,500	64	20	250	186	479	38
39	Air Ventilation System	2004	26,794	687	20	2,233	1,546	3,535	39
40	Design & Development of Town Square	2004	42,130	1,080	20	4,213	3,133	7,724	40
41	Consultancy Fire alarm Installation	2004	22,700	7,264	20	3,243	(4,021)	5,675	41
42	Hand Rail System	2005	6,025	122	10	502	380	502	42
43	Duct Detectors	2005	2,061	42	5	344	302	344	43
44	20 Ton Roof Top Aircon	2005	17,635	245	5	2,057	1,812	2,057	44
45	Elevator Fire Upgrade	2005	46,440	646	5	5,418	4,772	5,418	45
46	Concrete Approach Pad	2005	2,160	21	10	90	69	90	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,905,132	$ 594,132		$ 594,102	$ 496	$ 8,250,551	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,059,376	$ 97,618	$ 152,352	$ 54,734	10	$ 713,775	71
72	Current Year Purchases	61,101	11,967	6,207	(5,760)	10	6,207	72
73	Fully Depreciated Assets	1,047,407	1,160	4,186	3,026		1,047,407	73
74			949	949				74
75	TOTALS	$ 2,167,884	$ 111,694	$ 163,694	$ 52,000		$ 1,767,389	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,849,804	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 705,826	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 757,796	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 51,970	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,017,940	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: ***N/A - Related Party Lease***

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		***Off-site Public Storage***			1,324			5
6								6
7	TOTAL				$ 1,324 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 466,796	$		$ 466,796	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			59,170			59,170	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			555,819			555,819	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				297,917		297,917	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Med Sup/SpBed Rent	39-2					24,577		24,577	13
14	TOTAL			$		$ 1,081,785	$ 322,494		$ 1,404,279	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Norridge Healthcare & Rehab Centre **#** 0032011 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (288,694)	$ (288,694)	1
2	Cash-Patient Deposits	109,345	109,345	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,268,938	4,268,938	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	78,704	78,704	6
7	Other Prepaid Expenses	2,395	2,395	7
8	Accounts Receivable (owners or related parties)		700,759	8
9	Other(specify): Employee Advances	13,429	13,429	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,184,117	$ 4,884,876	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		776,788	13
14	Buildings, at Historical Cost		10,519,965	14
15	Leasehold Improvements, at Historical Cost	842,663	1,385,165	15
16	Equipment, at Historical Cost	1,683,214	2,167,886	16
17	Accumulated Depreciation (book methods)	(1,747,402)	(12,138,964)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		162,166	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(162,166)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Goodwill	100,000	100,000	22
23	Other(specify): Construction In Progress		3,840	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 878,475	$ 2,814,680	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,062,592	$ 7,699,556	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 283,948	$ 284,948	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	322,327	322,327	28
29	Short-Term Notes Payable	49,708	49,708	29
30	Accrued Salaries Payable	779,605	779,605	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,529	28,529	31
32	Accrued Real Estate Taxes(Sch.IX-B)	511,500	511,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,975,617	$ 1,976,617	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	111,690	15,000,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 111,690	$ 15,000,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,087,307	$ 16,976,617	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,975,285	$ (9,277,061)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,062,592	$ 7,699,556	48

***(See instructions.)**

Facility Name & ID Number Norridge Healthcare & Rehab Centre **#** 0032011 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,127,999	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,127,999	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(152,714)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (152,714)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,975,285	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Norridge Healthcare & Rehab Centre **#** 0032011 **Report Period Beginning:** 1/1/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after Consolidation		
1	**Balance at Beginning of Year, as Previously Reported**	$ (9,052,674)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (9,052,674)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	275,613	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(500,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (224,387)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (9,277,061)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,512,150	1
2	Discounts and Allowances for all Levels	(2,961,063)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,551,087	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,815,346	6
7	Oxygen	12,481	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,827,827	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	452,198	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,023	19
20	Radiology and X-Ray	49,980	20
21	Other Medical Services	158,004	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 679,205	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	113	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 113	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Commissions	6,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,064,232	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,601,892	31
32	Health Care	6,165,341	32
33	General Administration	2,722,320	33
	B. Capital Expense		
34	Ownership	3,150,651	34
	C. Ancillary Expense		
35	Special Cost Centers	1,404,279	35
36	Provider Participation Fee	172,463	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,216,946	40
41	**Income before Income Taxes (line 30 minus line 40)****	(152,714)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (152,714)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation. *Cash Basis Tax Payer**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,860	2,238	$ 102,379	$ 45.75	1
2	Assistant Director of Nursing	1,836	2,206	82,048	37.19	2
3	Registered Nurses	67,018	71,557	1,905,905	26.63	3
4	Licensed Practical Nurses	16,734	17,969	450,091	25.05	4
5	CNAs & Orderlies	170,136	182,526	1,950,599	10.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,930	2,249	47,106	20.95	9
10	Activity Assistants	9,839	10,813	110,670	10.23	10
11	Social Service Workers	6,767	7,697	108,910	14.15	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	54,210	59,022	621,891	10.54	15
16	Dishwashers					16
17	Maintenance Workers	5,987	6,626	99,937	15.08	17
18	Housekeepers	37,154	40,152	380,790	9.48	18
19	Laundry	19,830	21,885	187,662	8.57	19
20	Administrator	1,924	2,206	92,580	41.97	20
21	Assistant Administrator	1,467	1,629	25,668	15.76	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,782	23,841	351,638	14.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	18,938	20,326	359,746	17.70	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	437,412	472,942	$ 6,877,620 *	$ 14.54	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	693	$ 20,787	1-3	35
36	Medical Director	956	38,250	9-3	36
37	Medical Records Consultant	101	3,608	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	504	7,560	10-3	39
40	Physical Therapy Consultant	199	6,971	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	14	670	11-3	44
45	Social Service Consultant	101	3,845	12-3	45
46	Other(specify) Dimentia Consultant	61	1,775	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,629	$ 83,466		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	9,098	$ 339,893	10-3	50
51	Licensed Practical Nurses	170	6,284	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	9,268	$ 346,177		53

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra Bernett	Administrator	N/A	$ 92,580
Barbara Dabrowski	Asst.Administrator	N/A	25,668
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 118,248

B. Administrative - Other

Description	Amount
Management Fees-Lancaster, Ltd.	$ 502,740
TOTAL (agree to Schedule V, line 17, col. 3)	$ 502,740
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Stone, Pogrund & Korey	Legal	$ 28,730
Myers Miller & Krauskopf	Legal	1,243
Finkel, Martwick & Colson	Legal	6,500
Caffarelli & Seigel	Legal	8,647
Emdeon Business Services	Data Processing	1,514
Health Data System	Data Processing	6,950
E Health Data Solutions	Data Processing	4,199
Accu-Med Services, Inc.	Data Processing	3,225
Personnel Planners, Inc.	Payroll Tax Consultant	2,445
Frost, Ruttenberg & Rothblatt	Accounting	4,170
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 67,623

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 109,785
Unemployment Compensation Insurance	98,495
FICA Taxes	514,966
Employee Health Insurance	353,973
Employee Meals	24,375
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	2,563
Retirement Plan Contributions	55,348
Misc. Employment Benefits	22,123
Employment Fees	94,845
Lancaster Allocation	92,706
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,369,179

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 500
Advertising: Employee Recruitment	15,307
Health Care Worker Background Check	
(Indicate # of checks performed)	4,520
Promotional Advertising	63,602
Dues & Subscrptions	1,050
Licenses & Fees	4,270
Related Parties Allocation	47,879
Less: Public Relations Expense	(47,879)
Non-allowable advertising	(61,243)
Yellow page advertising	(2,359)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,647

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	335
Seminar Expense	9,662
Lancaster Allocation	13,128
Entertainment Expense	(4,371)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,754

**See instructions.

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Painting & Decorating	Aug-99	$ 2,834		$ 472	$	$	$	$	$	$	$	$
2	Painting & Decorating	Nov-99	1,966		328								
3	Painting & Decorating	Mar-2000	585		98								
4	Painting & Decorating	Oct-2000	266		45								
5	Painting & Decorating	Nov-2000	50		8								
6	Painting & Decorating	Dec-2000	180		30								
7	Painting & Decorating	Aug-2001	1,281		427	427	213						
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 7,162		$ 1,408	$ 427	$ 213	$	$	$	$	$	$

Facility Name & ID Number Norridge Healthcare & Rehab Centre # 0032011 Report Period Beginning: 1/1/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **95,243** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **172,463**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **24,375** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.